DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

(X5) COMPLETION DATE
COMPLETION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K73W11

Facility ID:

000006

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155006	B. WIN			09/15/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MILLEDIG				1	N ALBER ST		
	S MERRY MANOR			WABAS	SH, IN46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	Quality review comp Cathy Emswiller RN						
F0155	•	he right to refuse treatment,					
SS=D		pate in experimental					
		ormulate an advance					
	•	ied in paragraph (8) of this					
	section.						
			F0	155	It is the policy of Millers Merr Manor, Wabash East, to ens		10/15/2011
		review and interview, the			that residents rights are follow		
		ensure the nursing staff			per regulatory guidelines. the		
	informed the resi	dent of possible			resident has the right to refus		
	complications rel	lated to repeated refusal			treatment, which could include	le	
	of physician ordered medications for 1 of 10 residents reviewed for medication				medications, as long as the	natod	
					consequences are communic tothe resident in a manner th		
	administration in	a sample of 15.			understandable to them.	atio	
	(Resident #15)	-			continued refusal of medicati	ons	
	,				will be assessed by the licen		
	Findings include:				nurse and the physician will I		
	<i>Q</i>				notified.I. Resident # 15; the plan has been revised to incl		
	1) Resident #15	's clinical record was			the residents refusal of	uuc	
	reviewed on 9/12				medications. the physican ha	ıs	
	Teviewed on 7/12	111 at 11.20 a.m.			been notified of refusal of		
	Dagidant #15's au	arrent diagnosis included,			medications.The family/resid	ent	
		_			have beed educated on the adverse effects that could		
		ted to, vascular dementia			possible occur due to the ref	usal	
	· ·	ypertension, atrial			of physican ordered meds.II.		
	fibrillation, anem	nia, and constipation.			residents have the potential t		
					affected by this deficient prac	ctice.	
		icare 90 day Minimum			All clinical records will be	antod .	
	` ′	assessment, dated 7/4/11,			reviewed. Any resident with redication refusals which co		
	indicated Resider	nt #15's cognition was			cause potential adverse effect		
	severely impaired	d.			the residnet will have this		
					documented on the plan of c		
	The clinical reco	rd lacked any			Physican will be updated. the		
	information relat	ed to the resident having			resident/POA will be educate the potential adverse effects		
	been informed of	the possible			medciation refusal.III. The	UI	
	occii illiolilled Ul	the possione			mediciation refusal.iii. The		

000006

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
	or condition.	155006	A. BUI B. WIN	LDING		09/15/2	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
MILLER'	S MERRY MANOR		1900 N ALBER ST WABASH, IN46992				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	complications rephysician ordere following dates: 7/2/11 Resident thinner) and Arid 7/10/11 Resident Acid (vitamin sur Sodium (stool so 7/20/11 Resident dose of Coumad 8/11/11 Resident Coumadin 8/13/11 Resident Coumadin 8/13/11 Resident Coumadin 8/20/11 Resident Coumadin 8/21/11 Resident Coumadin 8/21/11 Resident Metoprolol (blocand Coumadin 8/24/11 Resident Metoprolol, Risp 8/25/11 Resident Metoprolol, Risp 8/27/11 Resident Docusate Sodium During an intervent p.m., with the Desident having the serident having the series have the series having the series havin	lated to refusing d medications on the refused Coumadin (blood cept (used for dementia) to refused 8 p.m. Aricept to refused 9 a.m. Folic applement) and Docusate oftener) to refused 4 mg of 8 mg in ordered to refused Aricept and to refused Aricept to refused Aricept to refused Aricept to refused Aricept and to refused Aricept, and pressure), Risperidol, and Coumadin to refused Aricept, peridol, and Coumadin to refused Aricept, peridol, and Coumadin to refused Folic Acid and must be refused Folic Acid and must be refused related to the peen informed of possible for refusing physician			following measures will be printo place to ensure this defice practice will not reoccur. All nurses were re-educated on policy for medication refusal. MAR/TX records will be revied 3x's weekly by the DON or Designee for the next month, then 2x's weekly for 1 month then weekly thereafter for 4 months to ensure that the medication refusal are documented properly and appropriate notification have completed. IV. the corrective action will be monitored utilize the QA tool (exhibit A) medicated refusal, any issue and some some some some some some some some	the All ewed and been ing cation I be saues A	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED
		155006	B. WIN			09/15/2	011
	PROVIDER OR SUPPLIER		•	1900 N	ADDRESS, CITY, STATE, ZIP CODE I ALBER ST SH, IN46992	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
IAU	During an intervithe DoN indicate information to president having be complications from ordered medications. Review of a curror 2004, provided be 9/14/11 at 2:27 prefusal", include the following: "A. PURPO 1. To adminify according to guide manufactures labe conjunction with requirements. The Residence in the requirements are communicated manner that is uncontinued refusal.	dew on 9/14/11 at 4 p.m., d she had no additional rovide related to the leen informed of possible om refusing physician ons. ent facility policy dated by Social Services on lend, but was not limited to, SE lister medications delines set forth by leling guidelines and in Federal and State lident has the right to which could include ong as the consequences and to the resident in a liderstandable to them. It of medications, will be licensed nurse and the		IAU			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155006		A. BUILD		OO	(X3) DATE S COMPL 09/15/2	ETED	
	PROVIDER OR SUPPLIER			1900 N	DDRESS, CITY, STATE, ZIP CODE ALBER ST H, IN46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F0157 SS=D	resident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial status conditions or clinical tertreatment significant conditions or clinical tertreatment significant change in the psychosocial status conditions or clinical tertreatment significant change in conditions or clinical tertreatment significant condi	s in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due uences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the own, the resident's legal interested family member ange in room or roommate ecified in §483.15(e)(2); or int rights under Federal or ations as specified in of this section.					
	facility failed to onotified of a residued medications for	dication administration in Resident #15)	F01:	57	It is the policy of Miller's Merr Manor, Wabash East to ensu that Physican and Family Notifications are followed as regulatory guidelines. the res has the right to refuse treatm which could include medication as long as the consequences communicated to the residen manner that is understandab	per ident ent, ons, s are t in a	10/15/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
		155006	B. WIN			09/15/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹					
MULEDI				1	ALBER ST		
MILLER'S MERRY MANOR			WABAS	6H, IN46992			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					them. Continued refusal of		
	1.) Resident #15	5's clinical record was			medciations will be assessed	by by	
reviewed on 9/12/11 at 11:20 a.m.				the Licensed Nurse and the			
	leviewed on 3/12	2/11 at 11.20 a.m.			Physican and the Family will		
	D :1 . //15!				notifed. I. Resident # 15 : The		
		urrent diagnosis included,			physican and family have be notified of the residents refus		
		ited to, vascular dementia			medication.II. All residents ha		
	with delusions, h	nypertension, atrial			the potential to be affected b		
	fibrillation, anen	nia, and constipation.			deficient practice. All clincial	,	
		_			records will be reviewed. All		
	A Quarterly Min	nimum Data Set (MDS)			Nurses will be re-educated o	n the	
					policy for medication and		
	assessment, dated 7/4/11, indicated				notification refusal. Any resid		
		ognition was severely			with noted medication refusa	ls	
	impaired.				which could cause potential		
					adverse effects to the reside	-	
	The clinical reco	ord lacked any			have this documented on the Plan of Care. Physican will b		
	information related	ted to the resident's			updated. The resident/ POA		
		g been notified of the			be educated on the potential		
		medications on the			adverse effects of medication		
		, inedications on the			refusal.III. The following		
	following dates:				measures will be put into pla		
		refused Coumadin (blood			ensure this deficient practice	will	
	thinner) and Ario	cept (used for dementia)			not reoccur.All nurses were		
	7/10/11 Resident	t refused 8 p.m. Aricept			re-educated on the policy for		
	1	t refused 9 a.m. Folic			medication refusal.All MAR/1		
	Acid (vitamin su	ipplement) and Docusate			records will be reviewed 3x's weekly by the DON or Desig		
	Sodium (stool so	* * /			for the next month, then 2x's	ilee	
	`				weekly for 1 month and then		
		t refused 4 mg of 8 mg			weekly thereafter for 4 month	ns to	
	dose of Coumadin ordered				ensure that the medication		
	8/13/11 Resident	_			refusal are documented prop	erly	
	8/19/11 Resident	t refused Aricept			and appropriate notification h		
	8/21/11 Resident	t refused Aricept,			been completed.IV. the corre		
	Metoprolol (blood pressure), Risperidol,				action will be monitored utiliz		
	and Coumadin	r,p •,			the QA tool (exhibit A) medic		
		trafugad Arigant			refusal, any issue s noted wi		
		t refused Aricept,			addressed immediately. All is will be documented on the Q		
	Metoprolol, Risp	peridol, and Coumadin			will be documented on the Q	^	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155006		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 09/15/2	LETED
NAME OF PROVIDER OR SUPPLI		1900 N	ADDRESS, CITY, STATE, ZIP CO N ALBER ST SH, IN46992	DE	
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES SNCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
8/25/11 Reside Metoprolol, Ri 8/27/11 Reside Docusate Sodin During an interp.m., with the linformation was lack of physicia. Resident #15 resident #	nt refused Aricept, speridol, and Coumadin nt refused Folic Acid and mm view on 9/14/11 at 2:20 DoN, additional se requested related to the an notification in regards to efusing medications. view on 9/14/11 at 4 p.m., ted she had no additional provide regarding the lack offication for Resident #15 ations. Trent facility policy dated by Social Services on p.m., titled "Medication ded, but was not limited to,	IAG	log. this will reviewed monthly QA meetings months then the QA c will determine if the is resolved or if anyfurth needed.V. Date of Co 10/15/2011	for 6 ommittee sue is er action is	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
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			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
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MILLER'	S MERRY MANOR				SH, IN46992		
				l .	,		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	IAG	BELIEUE.(C.)		DATE
	physicia	n will be notified"					
F00.41	3.1-5(a)(3)	romata gara for regidents in					
F0241 SS=D	a manner and in a maintains or enhall and respect in full individuality. Based on observer interview, the fact the dignity of the members were of 2 of 7 residents viduring 1 of 2 din (Residents # 14 at #5). 1. During the sufficient #5:00 P.M., LPN Resident #22 a beside her. She gave her bites of 5:02 P.M. LPN #4 moved to table and gave R	romote care for residents in an environment that nees each resident's dignity recognition of his or her ation, record review, and cility failed to promote e residents when 2 staff beserved standing to feed who needed to be fed ing observations and #22 and LPNs #4 and pper meal on 9/12/11 at #4 was observed giving ite of food as she stood continued standing as she if food at 5:01 P.M. and o the other side of the esident #14 two bites of from a cup at 5:02 P.M.	F0	241	It is the policy of Millers Merr Manor, Wabash East to promous care for residents in a manner and in a environment that maintains or enhances each residents dignity and respect full recognition of his or her individuality. I. Resident # 22 resident # 14 showed no adverfects or distress related to deficient practice. Nurse # 4 #5 have been re-educated or proper feeding techniques for dependant residents. II. All residents dependant for feed have the potential to be affect by this deficient practice. III. Tollowing measure will be put place to ensure this deficient practice will not reoccur. All sere-educated regarding feeding dependant residents. Meals were be monitored by Administrate Designee, daily for 2 weeks, 3x's weekly for 1 month, ther weekly there after for 4 monthensure that residents are fed	in and erse this and in r ing ted the into staff g will or or or then in the to	10/15/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
		155006	A. BUILDING		09/15/2011
			B. WING		
NAME OF I	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE	
				I ALBER ST	
MILLER'S	MILLER'S MERRY MANOR			SH, IN46992	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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	LPN #4 returned	to resident #22 at 5:03		dignified and respectful	
	P.M. and stood a	s she gave her a bite of		manner.IV.The corrective ac	
	food.			will be montiored utilizing Q	
				(exhibit B) feeding procedur issues will be addressed	s. all
	I PN #5 stood an	nd fed Resident #14 a bite		immediately. All issues will be	oe l
		P.M. She continued to		documented on the QA log.	
		her food and drinks until		will be addressed in the mo	• • • • • • • • • • • • • • • • • • •
				QA meeting for the next 6	
		she got a stool and sat to		months. The QA committee	
	feed Resident #1	4.		determine if the issue is reso or if further action is needed	
				Date of compliance: 10/15/2	
	LPN #4 continued to stand and fed			Date of compliance. 10/15/2	.011
	Resident #22 mc	ore of her supper and gave			
	her drinks of liqu	aids. At 5:06 P.M., she			
		and sat down beside			
		d fed her as she sat on the			
		d led her as she sat on the			
	stool.				
	D :1 / //141 :				
		linical record was			
	reviewed on 9/14	4/2011 at 1:33 P.M.			
	Resident #14's d	iagnoses included, but			
	were not limited	to Alzheimer's disease,			
	macular degener	ation, and cancer of the			
	prostate.				
	Resident #14's In	uly 2011 recapitulation			
		the resident was on a			
		nectar thick liquids.			
	purced diet with	nectal unck liquius.			
	Dogidant #141-	manual MDC (minimum			
		nnual MDS (minimum			
	l ′	nent dated 7/21/2011			
	indicated he was	severely impaired for			
	decision making	and was totally			
	_	staff member for eating.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155006		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE S COMPL 09/15/2	ETED	
		155000	B. WIN			09/15/2	011
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
IAG	Resident #14's ca and revised on 4/of "Nutritional ridiet of pureed wiliquidFed by s Resident #22's cl reviewed on 9/12 Resident #22's di were not limited dementia with devascular disease. Resident #22's Ju orders indicated pureed diet. Resident #22's si assessment dated was severely improved making and was staff member for Resident #22's cu 10/28/2008 and real alast care plan refor the problem of	are plan dated 8/19/2010 /25/2011 for the problem sk related to:Therapeutic th nectar thick taff." inical record was 2/2011 at 2:10 P.M. dagnoses included, but to Alzheimer's disease, elusions, and peripheral ally 2011 recapitulation the resident was on a gnificant change MDS 17/20/2011 indicated she vaired for decision totally dependent on 1 eating. arrent care plan dated revised on 8/31/2009 with eview date of 8/12/2011 of "high risk nutrional to: choking risk is on		IAG			
	_	iew with the DON ng) on 9/15/2011 at 9:05					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETE			
ANDILAN	or correction	155006	A. BUILDING		09/15/2011
			B. WING STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		l	ALBER ST	
MILLER'S	S MERRY MANOR		WABAS	sH, IN46992	
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PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE
		ted the staff know better			
	· ·	ng time since I have seen			
	them stand to fee	d.			
	3.1-3(t)				
F0279	A facility must use	the results of the revise the			
SS=D		nensive plan of care.			
	The feeility record of	avalan a aananahansiva			
	_	evelop a comprehensive resident that includes			
	measurable object	ives and timetables to meet			
		al, nursing, and mental and ls that are identified in the			
	comprehensive as				
	The care plan mus	et describe the services that			
		t to attain or maintain the			
	_	practicable physical,			
		osocial well-being as 33.25; and any services that			
	would otherwise b	e required under §483.25			
		ed due to the resident's under §483.10, including the			
		tment under §483.10(b)(4).			
		review and interview, the	F0279	It is the policy of Millers Merr	
	_	ensure the nursing staff		Manor, Wabash East to use results of the assessment to	uie
	•	prehensive health care		develope, review and revise	I
	medications for 1	a resident refusing		residents comphrehensive pl care.l. Resident #15 : The ca	
		e plan development in a		plan has been revised to incl	
	sample of 15. (Re			the residents refusal of medications. The Physican h	128
				modications. The Frigoreal Fr	

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li ´			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155006	B. WIN			09/15/2011		
NAME OF I	DROLUDED OD GLIDDLIED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			1900 N	I ALBER ST			
	S MERRY MANOR			WABAS	SH, IN46992			
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	,	DATE		
					been notified of refusal of medications.II. All residents	havo		
	Findings include:				the potential to be affected b			
					deficient practice. All clinical			
	1.) Resident #15	's clinical record was			records will be reviewed. An			
	reviewed on 9/12	/11 at 11:20 a.m.			resident with noted medication	on		
					refusals which could cause			
	Resident #15's cu	irrent diagnosis included,			potential adverse effects to t resident will have this	ne		
		ted to, vascular dementia			documented on the plan of c	are		
		ypertension, atrial			Physican will be updated. The			
		ia, and constipation.			resident/POA will be educate	I		
	inormation, and	na, and consupation.			the potential adverse effects	of		
	A Ossantanlız Mad	icana 00 day Minimum			medication refusal.III. The			
	· · · · · ·	icare 90 day Minimum			following measures will be p			
	` ′	assessment, dated 7/4/11,			into place to ensure this defi practice will not reoccur.All	cient		
		nt #15's cognition was			nurses were re-educated on	the		
	severely impaired	1.			policy for medication refusal.All			
					MAR/TX records will be review	ewed		
		gust 2011 Medication			3x's weekly by the DON or			
	Administration R	lecords (MARs)			Designee for the next month then 2x's weekly for 1 month			
	indicated the resi	dent had refused			then weekly thereafter for 4	i aliu		
	medications on th	ne following dates:			months to ensure that the			
	7/2/11 Resident r	efused Coumadin (blood			medication refusal are			
	thinner) and Aric	ept (used for dementia)			documented properly and			
	7/10/11 Resident	refused 8 p.m. Aricept			appropriate notification have completed.IV. the corrective	peen		
		refused 9 a.m. Folic			action will be monitored utiliz	zina		
		pplement) and Docusate			the QA tool (exhibit A) medic	· '		
	Sodium (stool so				refusal. any issue s noted wi			
	`	refused 4 mg of 8 mg			addressed immediately. All i			
	dose of Coumadi	0 0			will be documented on the C)A		
		refused Aricept and			log. this will reviewed in the monthly QA meetings for 6			
	Coumadin	rerused rirroept and			months then the QA committ	tee		
		refused Arigant			will determine if the issue is			
	8/13/11 Resident	_			resolved or if anyfurther action			
	8/19/11 Resident	•			needed.V. Date of Complian	ce;		
		refused Aricept and			10/15/2011			
	Coumadin							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDING	00	COMPL	LETED
		155006	A. BUII B. WIN			09/15/2	011
		1	B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R		1	I ALBER ST		
MILLER'S MERRY MANOR			1	SH, IN46992			
WILLER	- WERRT WANDR		_	WADAS			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	8/21/11 Residen	t refused Aricept,					
	Metoprolol (bloo	od pressure), Risperidol,					
	and Coumadin						
	8/24/11 Residen	t refused Aricept,					
		peridol, and Coumadin					
		t refused Aricept,					
		* ′					
		peridol, and Coumadin					
		t refused Folic Acid and					
	Docusate Sodiur	n					
	The clinical reco	ord, reviewed on 9/12/11,					
	lacked any healt	h care plan related to the					
	resident refusing	g medications.					
	During an interv	riew on 9/13/11 at 4:30					
	_	dministrator and DoN,					
	1 *	nation was requested					
		•					
		ek of development of a					
		olan of care for Resident					
	#15 related to th	e refusing of medications.					
	The facility faile	ed to provide any nursing					
	comprehensive l	nealth care plan related to					
	_	sing medications for					
	Resident #15 as						
	Review of a curr	rent facility policy dated					
	_	by the DoN on 9/14/11 at					
	_	"Care Plan Development					
		uded, but was not limited					
	to, the following	; :					
	"1. PURPOSE:						
	A. To assur	e that a comprehensive					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155006		A. BUILI	DING	NSTRUCTION 00	(X3) DATE (COMPL 09/15/2	ETED	
			B. WING	_	ADDRESS, CITY, STATE, ZIP CODE	00/10/2	
NAME OF F	PROVIDER OR SUPPLIER				ALBER ST		
	S MERRY MANOR			WABAS	SH, IN46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAG		h resident includes	+	IAG			DATE
	ľ	ectives and timetables to					
		t's medical, nursing,					
		nosocial needs that are					
	identified in the	•					
	assessment proce						
		DEVELOPMENT:					
		omprehensive care plan is					
	designed to:	11 4 4 6 99					
		evidence that the facility					
		quate information to the					
		hey are able to make an					
		regarding treatment or					
	refusal of treatme						
		how evidence of efforts					
	to find alternative	e means to address					
	problems when r	esident is refusing					
	treatment						
	IX. Sh	now evidence that					
	treatment or serv	rices provided are to					
	attain or maintain	n the resident's highest					
	practicable physi	ical, mental and					
	psychosocial wel	ll-being"					
	2.1.25()						
	3.1-35(a)						
F0309		st receive and the facility					
SS=D		necessary care and services in the highest practicable					
		and psychosocial well-being,					
		n the comprehensive					
	assessment and p						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155006 09/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1900 N ALBER ST MILLER'S MERRY MANOR WABASH, IN46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE It is the policy of Millers Merry Based on interview and record review the F0309 10/15/2011 Manor. Wabash East that each facility failed to ensure a low blood resident will recieve and the pressure was assessed for 1 (Resident facility will provide the necessary #22) of 15 residents reviewed for care and services to attain or maintain the highest practical abnormal blood pressures in a sample of level of physical, mental and psycosocial well being, in accordance with the Findings include: comprehensive asserssment and plan of care.I. Resident #2: The licensed Nurse on duty did Resident # 22's clinical record was re-evaluate the residents blood reviewed on 9/12/11 at 2:10 p.m. pressure later in the shift, the Diagnoses included, but were not limited residents blood pressure was to: Alzheimer's disease, dementia with noted to be within limits, this was documented on the 24 hour delusions, vitamin b12 deficiency, and condition change report. Further peripheral vascular disease. assissement of residents B/P was also within residents normal range. The resident had no The facility "Occurrence Initial adverse effects. The Physican Assessment dated 6/1/11 at 16:20 (4:20 has reviewed resident's B/P's for p.m.), received and reviewed on 9/14/11, the month with out changes indicated Resident #22 received a small recommended.II. All residents skin tear while being dried after have the potential to be affected by this deficient practice. No other showering. Staff obtained vital signs of residents have been identified at blood pressure 71/49, heart rate of 75, this time. Vital signs records in respirations of 18, and temperature of the EMR(electronic medical 96.3. The document further indicated the records) were reviewed for all residents.III. The following physician and family were notified of the measures will be put into place. skin tear. There was no mention of the Staff re-education for Nurses low blood pressure noted. regarding vital signs and notification gudielines. All residents with changes of The "Weights and Vitals Summary", condition will be montiored every received and reviewed on 9/14/11, shift or as otherwise ordered by indicated on 6/1/11 at 16:52 (4:52 p.m.) the Physican until the issue is the resident's blood pressure to be 71/49. resolved. The information will be documented by the Licensed The next documented blood pressure, of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155006		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE: COMPL 09/15/2	ETED	
	PROVIDER OR SUPPLIER		STREET A 1900 N	ADDRESS, CITY, STATE, ZIP CODE I ALBER ST SH, IN46992	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION
F0323 SS=D	The "Weights an indicated the foll May 20, 2011 11 May 27,2011 94 June 1, 2011 17 June 2, 2011 11 June 3, 2011 11 June 4, 2011 10 June 5, 2011 11 June 5, 2011 11 June 5, 2011 11 Progress Notes "Progress Notes" An interview with Nursing, conduct a.m., indicated the pressure should be that time, and the assessment needs 3.1-37(a) The facility must be environment remains as is possible receives adequated.	4/52 1/40 18/66 04/51 14/64 07/64 18/66 Progress Notes" for on 9/14/11, indicated a a new physician order tin tear. No further for 6/1/11 were present. The the Director of ted on 9/15/11 at 9:00 he resident's blood have been rechecked, at en determine if further ed. Insure that the resident ins as free of accident sible; and each resident e supervision and assistance	TAG	Nurse in the EMR. The Physican/family will be notific condition changes per facility policy.IV. The corrective active be monitored by the DON/Designee utilizing the stool "24 hour condition chan This will be completed daily weeks, then 3'x weekly for tweeks, and then monthly thereafter ongoing per facility protocol. All issues identified be addressed immediately. It issues will be documented on QA log and this will be reiver in the monthly QA meeting ongoing.V. Date of Compliance:10/15/2011	ed of y on will QA ge". x's 2 wo y QA I will Any on the	DATE
		accidents. ation and interview the ensure 1 of 1 cookie	F0323	It is the policy of Miller Merry Manor, Wabash East to ens		10/15/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
		155006	A. BUII B. WIN		-	09/15/20	011	
			STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF	PROVIDER OR SUPPLIEI	2		1				
			1	ALBER ST				
MILLER.	S MERRY MANOR			WABAS	SH, IN46992			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	ovens were not a	accessible to residents,			that the resident environmen	t		
	without supervis	ion.			remains as free of accident			
					hazards as is possible; and e	each		
	Findings in deal				resident recieves adequate			
	Findings include): -			supervision and assistive de	vices		
					to prevent accidents.l. No	uio I		
	The environmen	tal tour was conducted on			residents were affected by the deficient practice. II. All reside			
	9/13/11 at 3:00 p	o.m. with Maintenance			have the potential to be affect			
	Assistant #6, Ma	nintenance Assistant #7			by this deficient practice.III.			
	1	ing Supervisor #8.			following measure was			
	and Housekeep	ing supervisor no.			implemented on 9/13/2011,	Гһе		
	T. 41				cookie oven was removed fro			
	1	ng room, a cookie oven			the Main Dining Room,			
	was observed to	_			immediately.IV. The corrective	/e		
	countertop of the	e storage cabinetry. The			actions are: Maintenance or			
	cookie oven was	sitting in front of an			designee will do daily safety			
	electrical outlet	with the on /off switch			checks to ensure that the co			
		and was easily accessible			oven is behind a locked door			
	1				the Activity room. The door lo of the Activity room doors we			
	1 -	The oven was not			replaced with, automatic lock			
	1	oors to the dining room			handles and closures to ensi	- 1		
	are left open. T	the dining room is not			ongoing resident safety			
	staffed during no	on-meal times. Residents			measures. The checks will be	e		
	were observed th	nrough out the survey			done daily, using QA tool (
	1	ut of the dining room			exhibit E), this will be done	daily		
	1	ce was not available.			x's 2 weeks, then 2x's weekly	y for		
	which filear servi	ee was not available.			1 month, and then monthly			
	.				checks thereafter for 6 month			
		onducted at the same time,			ensure compliance. Any issu			
	with Maintenance	ce Assistant #7 indicated			will be addressed immediate			
	the cookie oven	should not have been			documented on the QA log. will be reviewed monthly in the			
	stored on the co	untertop and could			QA meeting for the next 6	10		
		otential hazard. The			months. The QA committee v	_{vill}		
	1	removed immediately.			determine if the issue is reso			
	COURTE OVEIL WAS	removed minieulately.			or if any further action is			
	l				needed.V. Date of compliance	ce:		
	1	Nursing, interviewed on			10/15/2011			
	9/14/11 at 9:05 a	ı.m., indicated there were						
	3 wandering resi	dents currently residing						

000006

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		155006	B. WIN			09/15/2	011
			D		ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
NAME OF P	ROVIDER OR SUPPLIER			1900 N	I ALBER ST		
	S MERRY MANOR				SH, IN46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	IAG	BEI ICIENCI)		DATE
	in the facility.						
	3.1-45(a)(1)						
F0332 SS=E	•	nsure that it is free of ates of five percent or					
	•	ation, record review and	F0	332	It is the policy of Millers Merr		10/15/2011
	interview the fac	ility failed to ensure 3 of			Manor, Wabash East to ensu		
		ng staff (LPN #'s 1, 2, 3)			the facility is free of medicati		
		dications correctly as			error rates of 5% or greater.I Resident #24: Resident #43		
		nysician for 3 of 8			Resident #54. None of the	u.i.u	
	residents (Reside	-			residents had an adverse eff	ect	
	,	ng medications during the			related to this deficient pract	ice.	
		which consisted of 42			LPN's #1,#2,#3 have	l	
	_				re-educated.II. All residents the potentila to be affected b		
		th 4 medication errors.			deficient practice.III. The follo	-	
	9 %.	a medication error rate of			measures will be put into pla ensure this deficient practice	ice to	
	Findings include	:			does not reoccur. All License Nurses/QMA's will be re-educated on medication	∌d	
	1 The clinical re	ecord for Resident #24			adminstration guidelines. All		
					MAR's have been reviewed a		
	was reviewed on	9/13/11 at 11:00 a.m			proper time adjustments hav been completed. The	е	
	Resident #24's c	urrent diagnoses			DON/Designee will observe		
		re not limited to, type 2			random medication passes of		
		, peripheral vascular			for 2 weeks, then 2x's weekly 2 weeks and then monthly	y tor	
	disease and depre	• •			thereafter for 6 months. The		
	arsease and depre	C331011.			consulting pharmacist also		
	Dagidant #24 1 4	la haalthaara plan datad			completes periodical medica	ıt6ion	
		l a healthcare plan, dated			pass audits.Licensed nurses	3	
		ndicated the resident had			complete annual skills check	for	
	a tocus area liste	d as, resident is insulin			medicatiion pass.IV. The	النبد	
			1		corrective action (exhibit D) v	√VIII	l l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155006	A. BUILDING	00	09/15/2011
		100000	B. WING	ADDRESS SITU STATE ZIR SODE	00/10/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE N ALBER ST	
MILLER'	S MERRY MANOR			SH, IN46992	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	1 *	ic. Interventions for this		be monitored utilizing the QA "medication pass". Any issu	
		ed, monitor blood sugar		observed will be addressed	
	as ordered and gr	ve insulin as ordered.		immediately. All issues will	
	Resident #24 had	l current physician's		be documented on the QA lo This will be reviewed in the	g.
	orders for the fol			monthly QA meetings for the	
		- ·· · -0 ¹		6 months. The QA committee	
	a. Monitor blood	sugar 3 times daily at		determine if the issue is reso or if further action is needed.	
	6:00 a.m., 11:00	a.m. and 4:00 p.m.		Date of compliance: 10/15/2	I
	b. Administer sli	ding scale Novolog			
	insulin subcutane	eously 3 times daily			
	based on blood s	sugar results as noted			
	below,				
	less than 150 = 1	4			
	151 - 200 = 16 un				
	201 - 250 = 18 un				
	251 - 300 = 20 u				
	greater than 300				
	Sieutei tiluii 500				
	During an observ	ration of the medication			
		1 on 9/12/11 at 11:15			
	a.m., LPN #1 ch	ecked Resident #24's			
	· ·	e resident's blood sugar			
	result was 132.	At 11:20 a.m. LPN #1			
	administered 14	units of Novolog insulin			
	to Resident # 24.	The nurse administered			
		taneously into the			
		en. Resident #24 was in			
		om at the time of the			
	observation.				
	Duning alternation	on on 0/12/11 st 11:45			
	During observati	on on 9/12/11 at 11:45			

l i			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155006	B. WIN	G		09/15/2	U11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					I ALBER ST		
MILLER'S	S MERRY MANOR			WABAS	SH, IN46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		4 was observed up in her					
		e dining room. The					
		red her lunch tray at					
	11:55 a.m. This	resulted in a time period					
	of 35 minutes fro	om the time the resident					
	received her insu	lin medication and the					
	resident received	her lunch meal.					
	Review of the 20	10 "Lippincott Nursing					
		cated at the Nurses					
		626, indicated the onset					
		nsulin medication was					
	10-20 minutes.						
	2. During the me	edication pass on					
	_	P.M., Resident #24					
		ing administered a sq					
	l ` ′	njection of 16 units of					
		(regular insulin) by LPN					
		e ordered dose based on					
	her sliding scale						
		nain dining room being					
	_ ^ ^	5:02 P.M. This was 42					
		had received her					
	injection of insul	in.					
	3. During the me	edication pass on					
	9/13/2011 at 1:30	P.M., Resident #43 was					
	observed being a	dministered his					
	medication of far	motidine (Pepcid)					
		ion) 20 mg (milligrams)					
	by mouth by LPI						
	Resident #43's cl	inical record was					
		3/2011 at 2:45 P.M.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE S	ETED	
		155006	B. WIN			09/15/2	011
	PROVIDER OR SUPPLIER S MERRY MANOR			1900 N	ADDRESS, CITY, STATE, ZIP CODE I ALBER ST GH, IN46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
	July 2011 indicate tab: give 1 tab by P.M." 4. During the med 9/13/2011 at 1:47 observed being a medication of med (milligrams) by reduced tab: give 1 tab by mode (Hold if sedated) tab: give 1 tag date (Hold if sedated). Review of the pool Administration P.9/13/2011 and produced tab: give 1 tag date (Director of Nurse). P.M. indicated "1 resident receives."	7 P.M., Resident #54 was dministered her ethadone 5 mg mouth by LPN #3. inical record was 6/2011 at 2:10 P.M. capitulation orders for red "methadone 5 mg tab: at haily 12:00 P.M. " and "methadone 10 mg rily at 4 AM and 8 PM., licy for "Medication					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155006	A. BUILDING B. WING	00	COMP 09/15/2	LETED
	PROVIDER OR SUPPLIER S MERRY MANOR		STREET A 1900 N	ADDRESS, CITY, STATE, ZIP C I ALBER ST SH, IN46992	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE